IDAHO DEPARTMENT OF
HEALTH & WELFARE

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1070 Hiline Road, Suite 370
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www.cfh.dhw.idaho.gov

CERTIFIED FAMILY HOME MODIFICATION / ANNUAL RECERTIFICATION

www.cfh.dhw.idaho.gov

☐ MODIFICATION TO THE APPLICATION FOR CFH CERTIFICATION

or

☐ REQUEST FOR ANNUAL RECERTIFICATION

Provider Name:	Telephone Number:
Address:	
Please check mark ALL that apply to the type of change requested:	
☐ Change in types of residents you wish to accept into your home.	☐ Change of Home Ownership:
☐ Change of Address:	☐ Change in Level of Care you wish to provide.
☐ Change in Provider Name:	☐ Other
☐ You no longer wish to be a Certified Family Home and your name will be removed from any lists of available homes requested from the Department.	

Signature of Provider _____ Date _____

Signature of Regional Staff _____ Date _____